No More Status Quo: How the New CDR Will Change Health Care

written by Theresa Hush | September 16, 2015

As CMS streamlines its Value-Based Reimbursement programs, the pressure is on for providers to participate. A better foundation is needed to support those changes, so providers can actually succeed. And Medicare's expansion of Clinical Data Registries (CDRs) may just be the answer.

CDRs could be the tipping point for transforming health care. Here's why: With better capabilities for performance measurement, more comprehensive databases, and expertise for more advanced outcomes analyses and research, CDRs can provide tools that have been missing for all stakeholders—providers, health plans and consumers.

What's a CDR and Why Is It Different?

The Clinical Data Registry has evolved from multiple efforts to measure effectiveness and improve outcomes at a patient level. Expanding the concept of the first disease registries, the specialty medical societies stewardship took the registry concept and developed clinical registry databases to determine the incidence of disease and variables associated with various interventions.

Once the "registry" concept was later re-used by Medicare for PQRS reporting, it spurred development of businesses—ranging from portals for reporting to more sophisticated technology companies encompassing data aggregation, performance measurement, analytics, performance improvement and, even, research. In 2014, registries became qualified separately as general reporting registries or Qualified Clinical Data Registries, QCDRs. ICLOPS, for example, has been a QCDR since 2014, but also qualifies as a reporting Registry.

With new Medicare regulations (including proposed regulations awaiting final implementation), the CDR—or "Q"CDR (Qualified Clinical Data Registry)—has some very important functions under current rules that set it apart, both from other methods of reporting and from registries that fulfill the simplest PQRS reporting, but not much more:

> Unique Option for PQRS Reporting, under which all patients, not just Medicare, are part of the measurement process;
> Measure Development, as Medicare allows QCDRs to customize and develop measures that can be used to establish a more relevant or specialty-focused quality measurement and reporting program, inclusive of performance.

Proposed rules expand CDR functions and create the possibility that the CDR could become a significant mechanism for improving quality and cost measurement, while identifying effective interventions for improving performance. Under the new regulations, CDRs would take on these additional functions:

> Serve as a mechanism for fulfilling the public or clinical data registry reporting requirements for EMRs under Meaningful Use;
> Report Meaningful Use;
> Receive Medicare claims data beginning in 2016;
> Report PQRS under a QCDR Group Reporting Option beginning in 2016.

Of the expansions in functionality, the public reporting requirement is by far the most intriguing. Public reporting requirements, especially as they increase under Stage 3 Meaningful Use, mean that Clinical Data Registries can become very large data aggregators for EMR data, improving the foundation for better performance measure development, benchmarking and even outcomes research.

The expansion is more significant given that there are several all-specialty registries with QCDR status currently. Unlike specialty-only CDRs, all-specialty CDRs can aggregate much more data and compare outcomes across specialties. The potential for evaluating differences in outcomes by specialty of physician, place of service and types of interventions or procedures could lead to a breakthrough in outcomes research on a scale far beyond current medical research.

How the New CDR Can Advance Change

Everyone working in Value-Based Health Care has been frustrated by a lack of real progress in the costs and outcome improvement. Shared Savings ACOs (MSSPs), EHR technology, PQRS reporting, Bundled Payments, Patient Centered Medical Home—none have universally delivered on their goals. The use of a CDR as a key component of measuring and improving performance

has the promise of resolving some intransigent problems:

> No alignment of accountability for patients and data. Patients still choose where they get care, yet providers are financially responsible for patients attributed to them by a formula, even if the patient goes elsewhere. Further, those providers have access only to their own data—so they can't always know if a patient was hospitalized or had procedures. If the provider participates in an ACO that gets Medicare patient claims, this patient activity is not detailed, nor is it available within a timeframe that would benefit the provider or ACO. Despite the enormous investments in clinical technology, analytics software and other tools, providers don't have the means to see the effect of their interventions.
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> The CDR, with its ability to collect Medicare claims data and inherent data collection capabilities (especially referring to QCDRs formed for clinical integration, PQRS reporting and ACO services, rather than specialty society registries), can improve alignment of patient responsibility and data and identify real gaps and needed patient interventions.
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> Lack of essential patient feedback. Surveys and feedback instruments are more often used now than in the past, but there is a scarcity of important information about patient decisions, belief systems, functionality and outcomes. The current technologies provide almost no mechanism for involving the patient beyond being a passive participant, and probably do more to alienate patients than involve them. Without dialogue and engagement, even with good intentions, providers can't make progress.
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> It is likely, building on requirements for validating data from EMRs and providers, that CDRs will develop or play a part in expanding patient involvement in outcomes. While there are many ways for this to take place, the wealth of provider and clinical data that will eventually build CDR databases will undoubtedly lead to patient outreach, development of comparative performance data that patients can use, and so on.
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> Providers are not uniformly on board, engaged or participatory in Value-Based Care. Most providers are neither strategically managing their futures nor pouring over their patient data. They are just trying to keep up. They are participating in ACOs because the option has been presented to them, and they are worried what might happen if they don't. And the ACOs may be forming for the same reason—better not to be the last one stuck at the old party with no dance partners! But without complete data, they can't meet their goals.
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> By increasing the availability of more comprehensive data to providers as well as the better data and analyses for performance improvement, CDRs stand apart from other

vendor technology. A good CDR will have more than “tools” and will offer depth-of-data and research capabilities that will engage providers who care less about “performance,” as defined by their business environments, and more about outcomes.

Too much focus on absolute reporting numbers rather than outcomes. As a result of the quality reporting requirements of both PQRS and Meaningful Use, providers have focused on meeting absolute requirements and static performance measurement targets. Given the gaps in clinical and patient feedback data that make outcomes harder to see, rewarding or penalizing providers based on absolute numbers has been one of the only options.

The new CDR will make it possible to evaluate progress in improving outcomes, instead of limiting focus to absolute targets. Along with added data depth and volume, the CDR makes it possible to develop a quality program that approaches a systematic and comprehensive effort to improve outcomes not just in “populations,” but also in hard-to-reach and high-risk patients.

Watch for Emerging Clinical Data Registries

There have been a lot of changes in health care as employers, health plans and government transitioned from negotiating price to considering value. Hindsight, always being 20:20, makes it clear that the models of reimbursement came before the ability for providers to succeed.

At least on the Medicare front, the CDR expansion may be significant in helping stretch provider capabilities from lightweight or piecemeal efforts into more substantial, data-driven quality programs of depth and impact. Now that will be an interesting development!

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